MARIJUANA REGISTRY
PHYSICIAN'S MEDICAL VERIFICATION FORM

This form must be completed by the applicant's treating physician. **Failure to complete this form, which is three pages in length, in its entirety will render the patient's application incomplete.** Please note, for the purposes of completing this form, the definitions and penalties listed below.

DEFINITIONS

"**Bona fide physician-patient relationship**" means:

A treating or consulting relationship of not less than six months duration, in the course of which a physician has completed a full assessment of the registered patient's medical history and current medical condition, including a personal physical examination.

"**Debilitating medical condition**" means:

(A) Cancer, acquired immune deficiency syndrome, positive status for human immunodeficiency virus, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent and intractable symptoms; or

(B) A disease, medical condition, or its treatment that is chronic, debilitating and produces severe persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain, severe nausea or seizures; and

(C) Reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms.

"**Physician**" means:

A person who is:

(A) licensed under chapter 23 or chapter 33 of Title 26, and is licensed with authority to prescribe drugs under Title 26; or

(B) a physician, surgeon, or osteopathic physician licensed to practice medicine and prescribe drugs under comparable provisions in New Hampshire, Massachusetts, or New York.

PENALTIES

Notwithstanding any law to the contrary, a person who knowingly gives to any law enforcement officer false information to avoid arrest or prosecution, or to assist another in avoiding arrest or prosecution, shall be imprisoned for not more than one year or fined not more than $1,000.00 or both. This penalty shall be in addition to any other penalties that may apply for the possession or use of marijuana.

DO NOT DETACH PAGES

MEDICAL HISTORY RECORD

The Registry shall contact the physician for purposes of verifying the existence of a bona fide physician-patient relationship and the accuracy of the medical record. The Registry may approve an application, notwithstanding the six-month requirement, if the Registry is satisfied that the debilitating medical condition is of recent or sudden onset and that the patient has not had a previous physician who is able to verify the nature of the disease and its symptoms. The department shall approve or deny the application for registration in writing within 30 days from receipt.

Registered Patient	**Name**, Last	First	Middle
	Date of Birth	Telephone Number	

THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE REGISTERED PATIENT'S PHYSICIAN

PHYSICIAN INFORMATION

Name	Last		First	Middle
Office Mailing Address	Number	Street/P.O. Box		
	City		State	Zip Code
Office Telephone	Work		Other	

Physician's License # (License may be issued from Vermont, New Hampshire, Massachusetts or New York.)

Section 1 - Physician's Verification of a "Debilitating Medical Condition"

Please **initial** the following statements as appropriate.

	I am treating the patient for cancer and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for acquired immune deficiency syndrome and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for positive status for human immunodeficiency virus and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for multiple sclerosis and the disease, condition or its treatment results in severe, persistent, and intractable symptoms.
	I am treating the patient for a disease or medical condition (PLEASE SPECIFY) and/or its treatment that is chronic and debilitating, and that produces severe, persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain; severe nausea; or seizures.
	None of the above statements describe the patient's condition.

THE FOLLOWING SECTION SHOULD BE COMPLETED BY THE REGISTERED PATIENT'S PHYSICIAN

Registered Patient	**Name**, Last	First	Middle

Section 2 - Physician's Verification of a "bona fide physician/patient relationship"

Definition - The phrase "**bona fide physician-patient relationship**" means a treating or consulting relationship of not less than six months duration, in the course of which a physician has completed a full assessment of the registered patient's medical history **and current medical condition**, including a personal physical examination.

Please initial the appropriate box:

	I **have** a "bona fide physician-patient relationship" with the patient.
	I do **not** have a "bona fide physician-patient relationship" with the patient but the medical condition is of a recent or sudden and the patient has not had a previous physician who is able to verify the nature of the disease and its symptoms.
	I do **not** have a "bona fide physician-patient relationship" with the patient and 1) the medical condition is not of a recent or sudden onset; or 2) the patient has not had a previous physician who is able to verify the nature of the disease and its symptoms.

THIS FORM AS COMPLETED IS NOT INTENDED TO BE A PRESCRIPTION OR MEDICAL RECOMMENDATION FOR THE USE OF MARIJUANA.

I certify that I am:

licensed under chapter 23 or chapter 33 of Title 26, and is licensed with authority to prescribe drugs under Title 26; or

a physician, surgeon, or osteopathic physician licensed to practice medicine and prescribe drugs under comparable provisions in New Hampshire, Massachusetts, or New York.

And that I am a physician in good standing in the state of _____, and that the facts stated above are accurate to the best of my knowledge and belief.

Physician's Signature Date

PLEASE RETURN THIS FORM TO THE PATIENT WHOSE NAME APPEARS AT THE TOP OF THIS FORM.